JAMES E. RISCH – Governor RICHARD M, ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief BUREAU OF FACILITY STANDARDS 3232 Elder Street P.O. Box 83720 Boise, ID 83720-0036 PHONE 208-334-6626 FAX 208-364-1888

July 12, 2006

Kevin Ryan, Administrator Hillcrest Haven Convalescent Center 1071 Renee Avenue Pocatello, ID 83201

Provider #: 135018

Dear Mr. Ryan:

On **June 16, 2006**, a Complaint Investigation was conducted at Hillcrest Haven Convalescent Center. Marcia Key, R.N. and Lisa Kaiser, R.N. conducted the complaint investigation. A total of 30 survey hours were required to complete this investigation. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00001499

ALLEGATION #1:

The complainant stated that an identified resident's family member brought in a heating pad. A certified nurse aide put the heating pad on the resident's feet and left it on all night long on the highest setting. Subsequently, the resident sustained third degree burns and her right foot was blistered and turning black.

FINDINGS:

Based on observations, review of the identified resident's Incident/Accident report, record review, and staff interview it was determined the facility failed to protect the resident from accident hazards resulting in second and third degree burns to the lower extremity.

The facility was cited at F323 and F314 which constituted immediate jeopardy for the resident. The facility was also cited at F225 at the harm level secondary to not thoroughly investigating the incident.

Kevin Ryan, Administrator July 12, 2006 Page 2 of 3

CONCLUSIONS:

Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLÉGATION #2:

The complainant stated the facility did not transport the identified resident to the Emergency Room or call the doctor after she sustained second and third degree burns to her right lower extremity.

FINDINGS:

The identified resident's record was reviewed. It was determined the facility failed to keep the physician informed of the seriousness of the resident's lower extremity burns. Also, the facility failed to notify the physician or transport the resident on an emergent basis when she developed obvious cellulitis to the right lower extremity which required intravenous antibiotics and aggressive wound management.

The facility was cited at F323 at the level of jeopardy for failure to protect the identified resident from accident hazards, at F501 for failure to ensure medical supervision, assessment and management, and at F490 for failure to administrate the facility in a manner to maintain the highest practicable physical well-being of the identified resident. Both of these citations were at the level of harm.

CONCLUSIONS:

Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #3:

The complainant stated the identified resident received poor pain control.

FINDINGS:

The identified resident's record revealed she was receiving inadequate pain management.

The facility was cited at F309 at the harm level for failure to adequately control the identified resident's pain.

CONCLUSIONS:

Substantiated. Federal and State deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it will be addressed in the

Kevin Ryan, Administrator July 12, 2006 Page 3 of 3

Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

Lorene Kayser

MARCIA KEY, R.N. Health Facility Surveyor Long Term Care

MK/dmj

JAMES E. RISCH – Governor RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief BUREAU OF FACILITY STANDARDS 3232 Elder Street P.O. Box 83720 Boise, ID 83720-0036 PHONE 208-334-6626 FAX 208-364-1888

CERTIFIED MAIL: 7000 1670 0011 3314 8866

June 30, 2006

Kevin Ryan, Administrator Hillcrest Haven Convalescent Center 1071 Renee Avenue Pocatello, ID 83201

Provider #: 135018

Dear Mr. Ryan:

On June 16, 2006, a Complaint Investigation survey was conducted at Hillcrest Haven Convalescent Center by this Bureau to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency in your facility to be ISOLATED deficiencies that constituted immediate jeopardy to resident health and safety. You were informed of the immediate jeopardy situations in writing on June 16, 2006.

On June 16, 2006, the facility submitted a credible allegation that the immediate jeopardy was corrected. After review of your Plan of Correction, it was determined that the immediate jeopardy to the resident had been removed. However, the deficiencies as identified on the revised CMS Form 2567L remain and require a Plan of Correction. The most serious deficiencies now constitute actual harm that is not immediate jeopardy and that is isolated in scope, as evidenced by the CMS Form 2567L, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567L, listing Medicare/Medicaid deficiencies, and a similar form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in

Kevin Ryan, Administrator June 30, 2006 Page 2 of 5

compliance. After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567L and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by July 13, 2006. Failure to submit an acceptable PoC by July 13, 2006, may result in the imposition of additional civil monetary penalties by August 2, 2006.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

All references to federal regulatory requirements contained in this letter are found in *Title 42*, *Code of Federal Regulations*.

Based on the immediate jeopardy citations:

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F314 -- S/S: J -- 483.25(c) -- Pressure Sores
F323 -- S/S: J -- 483.25(h)(1) -- Accidents
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cited during this survey, we are recommending to the CMS Regional Office that the following remedies be imposed:

Denial of payment for new admissions effective as soon as notice requirements can be met. [42 CFR §488.417(a)]

A 'per instance' civil money penalty of \$5,000.00. (THIS REMEDY IS GENERALLY RESERVED FOR SITUATIONS OF SERIOUS NONCOMPLIANCE AS DESCRIBED AT \$7510) (§488.430)

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare &

Kevin Ryan, Administrator June 30, 2006 Page 3 of 5

Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **December 16, 2006**, if substantial compliance is not achieved by that time.

Your facility's noncompliance with the following:

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F314 -- S/S: J -- 483.25(c) -- Pressure Sores,
F323 -- S/S: J -- 483.25(h)(1) -- Accidents
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has been determined to constitute substandard quality of care as defined at 42 CFR §488.301. Sections 1819 (g)(5)(c) and 1919 (g)(5)(c) of the Social Security Act and 42 CFR §488.325 (h) require that the attending physician of each resident who was found to have received substandard quality of care as well as the State board responsible for licensing the facility's administrator be notified of the substandard quality of care. In order for us to satisfy these notification requirements, and in accordance with 42 CFR §488.325(g), you are required to provide the following information to this agency within ten (10) working days of your receipt of this letter:

The name and address of the attending physician of each resident found to have received substandard quality of care, as identified below:

Residents ##1 as identified on the enclosed Resident Identifier List.

Please note that in accordance with 42 CFR §488.325(g), your failure to provide this information timely will result in termination of participation or imposition of additional remedies.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/ Rainbow/Documents/medical/2001_10.pdf http://www.healthandwelfare.idaho.gov/ Rainbow/Documents/medical/2001_10_attach1.pdf

This request must be received by **July 13, 2006**. If your request for informal dispute resolution is received after **July 13, 2006**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

STATE ACTIONS effective with the date of this letter (June 30, 2006):

Due to the serious nature of the deficiencies at C789 and C790, the Department is placing the facility on a Provisional License. Enclosed is Skilled Nursing Facility License #4. This license is effective through December 30, 2006. The conditions of the Provisional License are as follows:

- 1. Correction of all the deficiencies, including C789, C790.
- 2. The facility must obtain weekly consultation from a qualified professional nurse who is not an employee of the facility. The facility's choice of a consultant must be approved by the Department. The consultant must provide weekly reports to this office, indicating each deficient area has been reviewed, corrective actions taken, and the current status of each deficient area.
- 3. A ban on all admission is being placed on the facility, effective the date of this letter, in accordance with *Title 3, Chapter 12, Rules Governing Long Term Provider Remedies in Idaho*, Section 16.03.12.004.08, which allows additional remedies when non-compliance with program requirements is found.

<u>IDAPA Section 16.03.12.004.08.</u>, states:

08. Ban on Admissions. Such bans to the facility or to any part thereof shall remain in effect until the State Survey Agency determines that the facility has achieved substantial compliance with all program requirements or until a substitute remedy is imposed.

Failure to comply with the conditions of the Provisional License may result in revocation of the facility's license. <u>IDAPA 16.03.02.003.05.a.</u> states:

- a. Additional causes for denial of a license may include the following:
 - I. The applicant has violated any conditions of a Provisional License.

Please be advised that you are entitled to request an administrative review regarding the issuance of the Provisional License. In order to be entitled to an administrative review, you must submit a written request to the State Survey Agency within fourteen (14) days from the date upon which you received this letter. The request must state the grounds for the facility's contention that Provisional License was inappropriate. Because a Provisional License may be issued whenever a facility is in substantial compliance with but does not meet every requirement or rule, during the review, you would be expected to demonstrate that none of the findings of deficiency were justified.

Kevin Ryan, Administrator June 30, 2006 Page 5 of 5

In any administrative review, you should be prepared to demonstrate that the Department's findings were in error.

You should also include any documentation or additional evidence that you wish to have reviewed as part of the administrative review. Your written request for administrative review should be addressed to, Randy May, Deputy Administrator, Division of Medicaid, 3232 Elder Street, PO Box 83720, Boise ID 83720-0036, Phone #: (208) 334-5747, Fax #: (208) 364-1811.

The rules and regulations governing the conduct of an administrative review are set forth at <u>IDAPA 16.05.03.300</u>. If you fail to timely request an administrative review, the Department's decision to impose remedies as set forth herein becomes final. Please note that issues, which are not raised at an administrative review, may not later be raised at higher level hearings (<u>IDAPA 16.05.03.301</u>).

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

LORETTA TODD, R.N.

Supervisor

Long Term Care

LT/dmj

Enclosures

PRINTED: 06/29/2006 FORM APPROVED OMB NO. 0938-0391

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	home." The DON was inter regarding the incide "the CNAs found #1] at 0600it had brought the heating stated that nobody heating pad on the resident had been 'night and nobody re pad. She stated, " someone placed the At 6:00 am, staff puresident's heels. The had not interviewed evening shift on 5/1 placed the heating. She could not offer the resident could he resident could he night and nobod near her body. On esurveyors, the DON members to gain mincident. Staff mem work were able to we recorded information the telephone. The LN on duty on 6/15/06. The LN not the resident's room, pad under her [resident] under her [resident	viewed on 6/15/06 at 3:50 pm, ent of 5/18/06. She stated, the heating pad on [resident been on all nightthe family pad in that day"The DON had admitted to placing the resident initially and that the 'toileted twice" during the emembered seeing the heating at some time during the night, e heating pad on her chest" It the heating pad between the pad on the resident initially. The book at the staff who worked the 7/06 regarding who may have pad on the resident initially. The any information regarding how have been toileted twice during dry noticed a heating pad on or 6/15/06, at the request of the labers who were scheduled to write statements and the DON on from staff she spoke with on the heel and bottom of did the skin around the red area. No documented that she had		225	The answers to the st are not an admission they cannot be used a in a court of law. The Medicaid and Medi	of guilt gainst t ey are r	. Therefore his facilit equired by
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"F 225	applied a brace to documented, "A came and got me At this time, I unw the ankle having on the heel and be then got two clean/new role the ankle and foo orthoses] brace be On 6/15/06, the Ewho worked on 5 following: "Med[ic [4:30 am] for pain that she was c/o extremities. Had non Res. [resident work the next not con 6/15/06, the Eworked the night documented the fineating pad on he [11:00 pm]. She was to 100 [1:00 am] repositioned. Unoplaced on her [lower] leg/feet pathought the heating asked him to turn 2nd or 3rd setting was white [with] at The facility failed	st aid for the reddened area and of the resident's foot. The LN at 0930 [9:30 am] the aid [sic] once again to look at the ankle. Trapped the foot and I observed a blister on it and the red area ottom of foot was blistered. In how non-adhesive pads and its of curlex [sic] and re-wrapped the and put the AFO [ankle-foot ack on." ON spoke with a night shift LN (18/06. She documented the ated] [resident #1] [at] 0430 when he was notified by CNA (complaining of] pain in lower no knowledge of a heating pad [at] any time until he came to complain [after] incident." ON spoke with an NA who shift on 5/18/06 and following: "Stated he saw the er chest on 1st Rounds [at] 2300 was checked for bathroom need [0300 [3 am] [and] also blear as to when the pad was ever] legs [and] ankles but [at] the time that she was comin. [NA's name] said that he are pad had 4 settings [and] she it up. He thought he set it on the Recalled that the heating pad white cover."	F _x 2	225	The answers to the st are not an admission they cannot be used a in a court of law. T by the Medicaid and M	of guilt. gainst th hey are r	Therefor is facili equired	
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•	that staff observed resident's chest at evening of 5/17/06 heating pad was on she was toileted at setting the heating between the residenthe heating pad on incident. The DON been removed from that facility staff had defectiveness or a DON acknowledge all the staff who we time period. She devening shift staff the resident was puritten statements interviews at the staff of the staff of the staff of the staff of the statements of the statements of the staff of the statements of the staff of the statements of the statements of the staff of the statements of the staff of the staff of the statements of the staff of	treport did not mention the fact the heating pad on the approximately 11:00 pm in the why staff did not notice the nor near the resident when 1:00 am and 3:00 am, what pad was on when it was found ent's heels, or if staff had used the resident before this noted that the heating pad had not examined it for possible malfunction. The did that she had not interviewed orked in the facility during that id not interview any of the who worked on 5/17/06 when ut to bed. The DON obtained and conducted telephone urveyors' request during the ation to gain more information ent.		The answers to the st are not an admission they cannot be used a in a court of law. The Medicaid and Medi	of guilt. Therefore, gainst this facility hey are required by
F 309 SS=G	Each resident mus provide the necess or maintain the hig mental, and psych	of CARE It receive and the facility must cary care and services to attain hest practicable physical, osocial well-being, in the comprehensive assessment	F 3	1.) The resident was emergency room and we to treat the wound, at have a follow up consattending physician. Certified Wound Care hired as a consultant dressed the wound app planahas been updated changes in the reside	sultation with the In addition a Specialist has been and has treated and propriately. The care is to reflect the
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PRINTED: 06/29/2006 FORM APPROVED OMB NO. 0938-0391

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 309	review, and a compwas determined the resident was provided ongoing medical as after sustaining bur resulted in physical 1 sample residents thermal burns to the medial lower extrer resident experience course of the next 2 Resident #1 was ac 4/12/06 with diagnous cerebral vascular a vascular dementia, edema, leg pain, particular 50 mg (milling needed. She was a mg four times per composition of the resident's MAFF Fentanyl 25 mcg [minitiated on 5/8/06. Physician telephone following: *5/23/06 - "PT [physician."	plaint from the general public, it is facility failed to ensure a led an initial evaluation and issessments by a physician ins. This deficient practice and psychosocial harm to 1 of (#1). Resident #1 sustained is right medial heel and right inity on 5/17/06 or 5/18/06. The led increasing pain over the led	F 309	rewritten to ensure an from pain is monitored the pain is not releive the current physician is notified and new or The care plan and the reflect the current physician a treatment plan that intended effect our Me be notified and asked attending physician. The resident and or the party will be consulted would like to change a Physicians will be not in conditions of their conditions of their 2.) All patients in the anew skin assessment DNS on 6-19-06. Chang have been made to reflection. 3.) Our pain management rewritten, and inservite to our staff to inform policy. In addition in held regarding, our sked dressing changes. 4.) Our DNS and our committed these programs nursing staff are followed and pain management care and pain care	d closely, yed after orders, to ders are treatment hysician of is not had is not had is not had it consul. If this is neir respond and ask attending if ied of a patients the completed ges in the lect the completed in them of inservices are particularly of the completed in the control of inservices are particularly our notificati	and if following he physic obtained. plans wi rders. If t change ving the ector will t with the sineffect onsible ed if the physician all change ity had by our care pla urrent co has been eing give this new are bein rogram ar ee will e our policies	ges ill f ill ne ctiv ns. ges
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Event ID: YZSO11

Facility ID: MDS001240

If continuation sheet Page 8 of 41

The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and Medicare program.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		[` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		135018	B. WII	NG_		i	C 6/2006	
	PROVIDER OR SUPPLIER	ESCENT CTR			TREET ADDRESS, CITY, STATE, ZIP CODE 1071 RENEE AVE POCATELLO, ID 83201			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	N
F 309	[every] 3 days for p *6/11/06 - [Change Q [every] 4-6 hours [hours], call [reside comfort level." *6/12/06 "dc [discont [four times per day] [change] duragesic The "Pain Assessr documented the rest "[right] heel/bilate "decubiti/ulceration the assessment for was documented as indicators present of grimacing, moaning assessment docum was started on 5/8/helped to relieve the A "Resident Incider Report," dated 5/18 two CNAs had ente her out of bed and of "between her hee the CNAs "observ heel" and notified The resident's nursi dated 5/18/06 at 3:3 family brought heati res[ident] requested Nursing staff was un RM [room]. Aids [sic	ain." J Ultracet to [two] tabs[tablets] prn [as needed] x [times] 48 nt's physician] [after] that [with] Intinue] ultracet/ - vicodin 5 QID PRN for breakthrough pain patch to 50 mcg." ment" form dated 5/12/06, sident had "chronic" pain in her ral heel" due to a "In the "Severity" portion of mether resident's pain scale is 8 to 9 and non-verbal evere documented as "crying, puretracts legs." The mented that a Fentanyl patch 26 and that Vicodin 5/500 mg a pain. at/Unusual Occurrence //06 at 7:20 am, documented red the resident's room to get discovered a heating pad ls." The report documented red some redness on the Right a nurse immediately. In notes revealed an entry so pm that stated, "Res[ident] ng pad in from other facility, heating pad to be put on. haware of heating pad, put on found heating pad, put on	F	309	The answers to the stare not an admission they cannot be used a in a court of law. The Medicaid and Medicaid	of guilt gainst t hey are	icienci . There his fac require	fdre ilit
	heel" and notified The resident's nursidated 5/18/06 at 3:3 family brought heatires[ident] requested Nursing staff was us RM [room]. Aids [sid	a nurse immediately. ng notes revealed an entry 80 pm that stated, "Res[ident] ng pad in from other facility, heating pad to be put on. haware of heating pad was in						

STATEMEN' AND PLAN (TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION 3	(X3) DATE SU COMPLE	TED	
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	PROVIDER OR SUPPLIER	ESCENT CTR		10	EET ADDRESS, CITY, STATE, ZIP CODE 071 RENEE AVE OCATELLO, ID 83201			
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F 309	Res [with] 2 blisters MD [medical docto During the complai of the surveyors, the a statement on 6/1 she arrived in the resolution of foot, whether ed area it blanthat she had provide reddened area and resident's foot. The [9:30 am] the aid [stagain to look at the unwrapped the foothaving a blister on and bottom of foot clean/new non-adhrolls of curlex [sic] foot and put the AF back on." The resident's nurs 5/18/06, document well as occurrence help shortly after a Nursing notes from documented the foots for the foots and put the AF back on."	s on feet, notified family [and] r]" Int investigation, at the request the LN on duty on 5/18/06, wrote 5/06. The LN noted that when esident's room, she observed of the resident #1] R [right] upon assessing the right leg, and area on the heel and the leg applied a brace to the leg applied a brace to the leg and leg and got me once the leg and leg and got me once the leg and leg and got me once the leg and the red area on the heel was blistered. I then got two desive pads and two clean/new and re-wrapped the ankle and leg and re-wrapped the ankle and leg and leg and re-wrapped the ankle and leg and re-wrapped the ankle and leg and resident crying out for ded issues regarding pain as sof the resident crying out for dmission to the facility.	F	309,	The answers to the stare not an admission they cannot be used in a court of law. the Medicaid and Medicaid an	tated def of guilt against t They are	. Therefo his facil required	re it:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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	ROVIDER OR SUPPLIER	ESCENT CTR		107	ET ADDRESS, CITY, STATE, ZIP CODE 71 RENEE AVE DCATELLO, ID 83201			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
Ę 309	*5/20/06, 3:00 pm - 'help me help me, vasked what she negeneral complaints Repositioned" *5/21/06, 9:30 pm - from clear drainage pm] [1] pain pill give statements, [no] su Seems more pleas *5/22/06, 2:00 pm - & intact. Given Ultracalled physician to could be ordered. Sphysician. Will continued by the could be ordered. Sphysician returned physician returned suggest pain *5/22/06, 3 pm to 1 [and] combative - E [physician] returned med. Suggest pain *5/30/06, 10 pm - "I [changed] and Ultracand back pain[Na attempted per phor was closed. Theref [appointment] tomo *5/31/06, 10 pm - "I frequently. Res give call light frequently Res wants boots of	uiet. C/O [complains of] pain Ultram" "0730 [7:30 am] Yelling out won't somebody help me' when eded she had a wide array of - Ultram given. "Blister open, dressing wet e, re-wrapped [at] 1730 [5:30 en, verbally negative ccess [with] redirection. ant when in recliner" "Dressing to blister clean dry am for pain. Uneffective - see if something stronger still awaiting call back from inue to monitor." 1 pm shift - "Demanding et benies any cares offered. Phys I call refused stronger Pain specialist appointment" Fentanyl 25 mcg patch am given, for c/o [right] foot ime of pain specialist] was ne for pain consult. Their office ore, will need to set-up appt.	T · ·	309	The answers to the sare not an admission they cannot be used in a court of law. the Medicaid and	of guilt against t They are	. Therefore this faciliarequired by	t

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
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F 309	given [at] 2100 [9 p c/o pain state[s] it is can't get relief. Fan be contacted tomos have appointment state appointment	en Res c/o foot pain Ultram [m] ineffective. Res continue to [s a #10 [on pain scale] and [nily requesting [pain specialist] [row [unable to read word]] [set up for Res." s c/o of pain in feet. [] fair results gave TLC" "Call to [resident's personal [g increased pain in] "Message left [with] MD office [patient's] increased pain, [patch not effective, requested edication." "[Resident #1] has been calling [f the day despite all efforts to [ning, chair to bed, bed [to] [down], medicated x2 w/ [with] [short time."] ted - "Ultram [one] PO [by [30 [9:30 pm] c/o pain]	F 30	The answers to the are not an admissi they cannot be use in a court of law. by the Medicaid an	on of guilt d against t They are	Therefore his facilit required

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NAME OF PROVIDER OR SUPPLIER STREE	1 RENEE AVE	
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(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE	
a more difficult time in the mornings - more calling out for help & being inconsolable - after lunch she appears calmer" *6/11/06, 3 pm to 11 pm shift - "Med[ication] [increased] to [two] for pain this shift - con't [continues] to c/o "I need help" & "Why don't you help" even while NS [nursing staff] is sitting beside her feeding her." *6/12/06, 10:51 am - "Medicated as ordered Res cont[inued] to call out for help" *6/12/06, 3:00 pm - "Med[ication] [change], Ultram d'cd [discontinued], Fentanil [sic] patch [increased] to 50 mcg, Vicodin 5 pm for breakthrough pain. Pt calling 'help me' when approached states 'you can't help me visit 1:1 [one on one] with [resident #1] and she seems to calm down and no longer needs help." *6/13/06, 10 pm - "[Resident #1] calling for 'help' most of this shift (3-11) when asked what she needed [resident #1] replies 'I don't know, I need help' unable to communicate what she needs or wants, if 1:1 with [resident #1] for 5-10 min[utes] she calms down and stops asking for help." *6/14/06, 2:15 pm - "Res requested pain med, [unable to read word] given [at] 1000 [10 am] 8/10 [on pain scale] effective 30 min later but [not] kept pain managed for long. Requested pain meds again [at] 1300 [1 pm] Called MD for alt[ernate] or another pain med, [no] answer, will call back." *6/15/06, 2:00 pm - "Called MD R/T pain managementwaiting for call back"	The answers to the stated deficiencies are not an admission of guilt. Therefore they cannot be used against this facility in a court of law. They are required the Medicaid and Medicare program.	it:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED		
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F. 309	On 6/15/06 at appr surveyors observed foot during a dress heel and lower extrin a reclined position protectors on. The Kerlix wrap which extremity, beyond be very red, taut an approximately 20 ankle region. The land the dressings. Kerlix wrap a faint area of the wound, approximately 5 feextremity. As the sof the wound, the following was observed with 50 - 6. The resident's medially, and 2 margins. There was deep red, medially, and 2 margins. There was deep red, medially, and 2 margins. There was irregularly shapproximately 3.5 covered with 50 - 6. The remainder of granulating tissue, skin was deep red along the inferolations along the surjections.	oximately 3:00 pm, the difference to wounds on her remity. The resident was sitting on. She had bilateral heel right lower extremity had a extended beyond the heel osed area of her anterior lower the Kerlix wrap, was noted to and edematous. This area was centimeters (cms) above the LN removed the heel protector. As the LN was removing the foul odor was emitted from the The surveyor was standing et from the resident's lower urveyor leaned within 2 - 3 feet odor was more apparent. The	F	\$09	The answers to the same not an admission they cannot be used a	of guilt against t They are	. Therefor his facilit required	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) M A. BUI		IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER EST HAVEN CONVAL	ESCENT CTR		1	REET ADDRESS, CITY, STATE, ZIP CODE 1071 RENEE AVE POCATELLO, ID 83201	- Park - San Land Communication Communicatio		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 309	Continued From pa	agę 14	, F	309	*	%		
	remained in her red Throughout the property and writhed in pain "hurry up" and finis son attempted to oprocedure but was during the dressing crying out in pain, to procedure but was during the dressing crying out in pain, to procedure but was during the dressing crying out in pain, to procedure the pain, to procedure the pain, to procedure the pain, to procedure the pain of the pain of the procedure that the procedure	g change, the resident cliner with her son at her side. Decedure, the resident moaned, at times telling the LN to the dressing change. Her comfort her throughout the unsuccessful. At one point g change as the resident was the LN stated, "I know rry so I can get you some pain resident stated, "You should pain medicine before you rethe dressing change, the ted back to her bed by 2 staff peroximately 3:20 pm, the LN the resident's pain medication. In the resident's pain medication. In the physician regarding the sident. When questioned to anyone from the facility had be physician regarding the sident's wounds she stated, "I be physical therapist] did or we we rely on our physical of the physical therapist of the number of the sident's right of the line she sustained the sident's right of the line she she sustained the sident's right of the line she she sustained the sident's right of the line she she sustained the sident's right of the line she she sustained the sident's right of the line she she she sustained the sident's right of the line she she she she she she she she she sh			The answers to the sare not an admission they cannot be used in a court of law. the Medicaid and Med	of guilt against t They are	Therefor his facilit required by	- 3

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F 309	regarding the resid The Assistant Adm was scheduled to sweek" for an initial staff were question orders from the phythe resident and the nursing staff. The Lipolicy or information nursing staff was ecall back from a doas inadequate pain it was appropriate to director. The facility's inaderesident's increasin harm to the resident on 4/12/06, the resident was exapter right lower extro 5/17 or 5/18 and a heel. Nursing notes struggle with pain a help. Even after the an evaluation by a facility did not get a 6/21/06, nearly a month of the did not get a facility did not get a 6/21/06, the reside she should have rethe dressing change.	ent's burns and pain issues. inistrator stated the resident see the pain specialist "next evaluation. The administrative ed about the delay in obtaining ysician for pain medication for e lack of follow up by the DON could offer no written in regarding how long the xpected to wait to receive a potor regarding situations such management or at what time to involve the facility's medical equate management of the int. From the day of admission ident suffered from chronic acerbated by thermal burns to emity and heel sustained on pressure ulcer to her right is documented the resident's and her history of crying out for the resident's physician ordered pain specialist on 5/22/06, the an appointment scheduled until anoth after the initial order. The country is a dressing change on the made a point of noting that be delived pain medication before	F:	309	The answers to the st are not an admission they cannot be used a	of guilt gainst t They are	. Therefor his facilit required by	t

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	ILTIPLE CONSTRUCTION DING	(X3) DATE SU COMPLE		
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F 309	an assessment by medical treatment aburns. A physician burns until 6/15/06, initially sustained the called immediate jetaken to a local emevaluation at the erwas diagnosed with intravenous antibio physician noted the regular physician was "aggressive phys [right] ankle" The diagnosed with MR Staphylococcus au and required aggressive and required aggressive and required aggressive physician was a statement of the control of the cont	a medical doctor and ongoing after she sustained the thermal did not evaluate the resident's nearly a month after she he burns, when the surveyors expandy and the resident was ergency room. Upon mergency room, the resident in cellulitis and was started on tics. The emergency room eresident was to see her within 3 days and was to begin ical therapy for debridement of resident was subsequently SA (Methicillin resistant reus) infection in her wound essive treatment with antibiotics aft to a wound specialist.	F 3	The answers to the are not an admission they cannot be used in a court of law. the Medicaid and Me	on of guilt lagainst t They are	. Theref his facil required	ore, ity
F 314 SS=J	Based on the compresident, the facility who enters the facility who enters the facility who enters the facility who enters the facility were unavoidable pressure sores reconservices to promot prevent new sores This REQUIREME by: Based on observative reviews, and a conservation of the facility who entered the facility	orehensive assessment of a must ensure that a resident lity without pressure sores weessure sores unless the condition demonstrates that able; and a resident having eives necessary treatment and e healing, prevent infection and	F3	Specialistato assis	the woundary. inservices basis reg ogram and chniques. and plan o	wound ca and revi care trea to our s arding ou appropria	tment taff r te

PRINTED: 06/29/2006 FORM APPROVED OMB NO. 0938-0391

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F 314	did not develop a particulity. This failed harm, constituting (#1) sampled residunstageable pressheel. The facility coas to the circumstage actually developed was evaluated. The appropriate managinterventions to prefacility also failed trafter the unstageal observed by the stextremity became failed practice. The and third degree becontributed to the intervention of staff were provided failure to ensure the pressure ulcer. On 6/16/06 at 1:40 surveyors with an and the immediate. The plan of correct. "We will hire a CW Nurse] on a consure following for this fail.) A CWCN or Cettle 1.) A CWCN or Cettle 1.	pressure ulcer while in the practice resulted in serious immediate jeopardy to 1 of 1 tents who sustained a large ure ulcer to her right medial build provide no documentation ance of when the heel ulcer in the facility or that the heel e facility failed to implement gement or appropriate event further deterioration. The protocolor of the resident's physician ble pressure ulcer was first aff. The right heel and lower infected as a result of this e resident sustained second urns to the site which infection. The was brought to the attention of istrator, DON, and Assistant (16/06, at 10:00 am. These is with specific details of the interest of the in	F		ensure, she is receiving treatment as ordered by physician to heal the from developing any according problems. 3.) Our DNS has compliant in the care plans have been according to these assess the surveyors. 4.) Skin assessments our licensed staff and plans will be developed assessments. These accompleted on the follow. A.) Upon admissible B.) If there are lems licensed staff assessments weed. C.) If upon contitual skin assessment in the licensed staff attending physicians developed and the specialist. Order and a plan of the developed and the	wound an ditional leted skin i faciliupdated was ments was will be dispersion school sees sment the skin intaff will kly. In the skin intaff will he can the certified ers for the treatment he treatment he treatment he treatment he treatment will ments w	n assessment y and the here needs will be residents will be residents will be ment will ssion. Who suffer le order	ents e ed to by oble and selection beautiful red

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YZSO11

Facility ID: MDS001240

If continuation sheet Page 18 of 41

The answers to the stated deficiencies are not an admission of guilt. Therefore, they cannot be used against this facility in a court of law. They are required by the Medicaid and medicare programs.

STATEMENT AND PLAN C	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
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F 314	at 7:00 am. 2.) In order to ensure effected our Director is also completing to on every resident or will fax these to the by 2:00 pm. 3.) Review our curriprocedures includir and revise these portion on the consure this does not also the consure this does not be consured the consured in the consuments of the consume	re no other residents are or of Nursing and one other RN nead to toe skin assessments urretnly [sic] in our facility and surveyor on Monday, 6/19/06, ent wound care policies and ag treatment and prevention policies where necessary. To out occur again. ents of wounds on patients in es education to our staff on a rding our wound care program and care techniques. will be performed by our appropriate care plans will be n these assessment. These e completed on the following	F ;	314	total condition. Addinassessments will be consist for those residence skin impairment. E.) This will be monited Dietary Supervisor. The answers to the state are not an admission of they cannot be used again a court of law. The the Medicaid and Medica	ompleted ents suff ored by o and our ated defi guilt. gainst they are re	on a monthlering from 7-20-06 ur DNS, QA Nurse. ciencies Therefore is facility quired by

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	PROVIDER OR SUPPLIER	ESCENT CTR			REET ADDRESS, CITY, STATE, ZIP CODE 1071 RENEE AVE POCATELLO, ID 83201			
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_% F 314	will begin. 4.) A nutritional assupon each admissi who suffer from ski and supplements waccounts the Resid dietary assessmen monthly basis for the skin impairment. Defeation of the final state of the skin impairment. Defeation of the final state of the state of the final state of the final state of the resident's classical therapy as room with the survey in her recliner. Her	dmitted to the facility on oses including history of ccident, osteoarthritis, neuropathy, dysphagia, araparesis, low back pain and		314	The answers to the st are not an admission they cannot be used a in a court of law. T the Medicaid and Medi.	of guilt gainst tl hey are ;	Therefo his facil required	re it

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 v /	(X2) M A. BUI		PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		135018	B. WII	۷G		1	6/2006	
	ROVIDER OR SUPPLIER	ESCENT CTR		11	REET ADDRESS, CITY, STATE, ZIP CODE 071 RENEE AVE POCATELLO, ID 83201			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 314,	Kerlix wrap, was not edematous. This at centimeters (cms) LN removed the heat she LN was rem foul odor was emitt. The surveyor was sfrom the resident's surveyor leaned with odor was more appropriately attached black to 4.5 -5.0 cms. The item was deep red, make a cm medially, and 2 margins. There was resident's medial to 3.6 to 4.8 cms about was irregularly shat approximately 3.5 covered with 50 -6. The remainder of the granulating tissues skin was deep red, along the inferolated cms along the supanterior lower extra previously. After viewing the rewounds, the survey Administrator, the EDON at 4:30 pm. EAdministrator indicates the survey administrator indicates the survey	lower extremity, beyond the oted to be very red, taut and rea was approximately 20 above the ankle region. The red protector and the dressings. The red from the area of the wound. Standing approximately 5 feet alower extremity. As the thin 2 - 3 feet of the wound, the parent. The following was tall right heel was covered by ck, dry eschar, measuring 4.0 x mmediate surrounding skin asuring 4.5 cms inferiorly, 1.0 as a second wound along the ower extremity, approximately we the heel eschar. This wound	, F:	314	The answers to the st not an admission of g they cannot be used a	guilt. Th against th They are r	erefore, is facili equired b	ty

PRINTED: 06/29/2006 FORM APPROVED OMB NO. 0938-0391

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	IULTIPI LDING	LE CONSTRUCTION	(X3) DATE SU COMPLE	TED	
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	PROVIDER OR SUPPLIER	ESCENT CTR		107	EET ADDRESS, CITY, STATE, ZIP CODE 71 RENEE AVE DCATELLO, ID 83201	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 314	Contiqued From pa	age 21	, F	314	¥	¥	*	
	right heel and that verify that the "black was still present at the burn on the heel was still present at the burn on the heel. The surveyor spok telephone at 4:44 president was admit heel. The therapist asked him to assess instructed the staff attempt to remove was not sure if he When he saw the there was a blister. Once the blister op was again observed department had ply they initiated treatr first photograph ta original heel eschacopies of the right wounds for the surveyors of the right wounds for the surveyors and docur heel wound is 7.3 note that the heel from the previous burn (she had a [staff of the content of the surveyors. The Consection, also dated following: "Bruises legible] - rt [right] for the surveyors of the resident's additionally the surveyors. The Consection, also dated following: "Bruises legible] - rt [right] for the surveyors of the resident's additionally the surveyors. The Consection, also dated following: "Bruises legible] - rt [right] for the surveyors of the resident's additionally the surveyors. The Consection of the previous burn (she had a [staff of the previous	the physical therapist could k cap" on the resident's heel the time the resident sustained of from the heating pad. The therapist indicated the ted to the facility with a black also indicated that an LN as the heel. He recalled he to keep the area dry and not the black eschar. He stated he documented his assessment. The the original eschar on top of the original eschar de. He also stated the therapy notographs of the wounds since ment on 5/24/06. He stated the ken 5/24/06 showed the are the and lower extremity			The answers to the not an admission of they cannot be used in a court of law. the Medicaid and Me	guilt. They are	iciencies herefore his faci required	ity

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: MDS001240

STATEMENT AND PLAN C	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) N A. BU		IPLE CONSTRUCTION IG	(X3) DATE SI COMPLE	ETED	
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	ROVIDER OR SUPPLIER	ESCENT CTR		1	REET ADDRESS, CITY, STATE, ZIP COD 1071 RENEE AVE POCATELLO, ID 83201	E		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG	IX	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 314	nail It foot [word n medial side of 5th theel protectors on.' form identified the restremity bruising a buttock region. The the resident's right notes, dated 4/12/0 skin issues. There injury. The physical therar and was interviewed pm. He stated he hassessment notes evaluated the resid when she first came stated he was certated he was certated he was admitted to the site. He acknowled the site. The surveyors revised he was admitted to the site. The 4/13/06 through 5/1 impaired skin. This the initial nursing as The Skin Problem initiated on 5/18/06 were sustained. The a "blister burn" and was no documental	words not legible] cream apply of legible] 4th & 5th toe on one 2 inches long 1/8 deepBill. The body diagram on the multiple upper and lower and the open area to the right are was no identified injury to theel. The admission nurses are to the facility 6/15/06 do by the two surveyors at 6:10 and attempted to locate his for the time period when he ent's heel. "I didn't see her e in. I can't find my notes." He ain the resident had black heel prior to the thermal injury lowledged he was not sure if the facility with the pressure ewed the Daily CNA Skin documentation identified from 18/06 that the resident had no documentation contradicted assessment as identified earlier. Assessment Flow Sheet was the day the thermal injuries e right heel was described as the color was "purple." There tion prior to 5/18/06 that ent had black eschar on the	F	314	The answers to the are not an admission they cannot be used in a court of law. the Medicaid and Medicaid	on of guilt I against t They are	Therefore this faciling	ity

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE		
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	ROVIDER OR SUPPLIER	ESCENT CTR		1(EET ADDRESS, CITY, STATE, ZIP CODE 071 RENEE AVE OCATELLO, ID 83201			
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F 314	physical therapist be the resident had de pressure ulcer. The plan initiated to directly heel from further provulnerable areas	ician notification after the secame alerted by an LN that eveloped an unstageable ere was no immediate care ect the staff how to protect the ressure and to protect other one to increased pressure. assess, monitor and treat a to the resident's right heel that e was admitted to the facility, resulted in immediate	F	314	The answers to the state not an admission of guicannot be used against court of law. They are Medicaid and Medicare p	lt. The this fac require	refore, the	еу
F 323 SS=J	The facility must er environment remai as is possible. This REQUIREME by: Based on observat interviews, record republic it was deensure a resident's accident hazards a resulted in serious	nsure that the resident ns as free of accident hazards NT is not met as evidenced ions, staff and family review, and a complaint from stermined the facility failed to a environment remained free of s possible. This failed practice harm, constituting immediate	F	323	ured their environmen ards as possible. 1.) The heating pad the facility. 2.) The rooms of all been thoroughly check no other heating pads 3.) Signs have been indicating the use of prohibited. We have our admission agreeme	t is as that has been other red to en in our posted in heating added lant indic	removed fresidents has the facility. In the facility pads is a surguage to ating the	rom ave are lity use
	heating pad was pl feet and lower extra at the 2nd and 3rd sustained thermal and right medial lov 5/18/06. The reside	#1) sample residents. A aced on or near the resident's emities causing thermal burns degree level. The resident burns to the right medial heel wer extremity on 5/17/06 or ent experienced increasing se of the next 27 days. The			of heating pads is prout a notice to all'f of our policy regardi will provide quarterl staff of our policy restaff and memebers of monitor the facility during their QA round	amiliesing heati y inserv egarding the QA for heat	imforming ng pads. W ices to re- heating p- committee ing pads	them le mind ads. will

				IULTIPLE CONSTRUCTION LDING	(X3) DATE S COMPLI	
		135018	B. WING		C 06/16/2006	
ĺ	ROVIDER OR SUPPLIEI			STREET ADDRESS, CITY, STATE, ZI 1071 RENEE AVE POCATELLO, ID 83201	······································	
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, F,323	resident had an in medical assessm sustaining the but thoroughly invest surrounding this in the facility's Administrator on facility was provide failure to ensure remained free of the Administrator allowed in the facility was provided in the facili	ide no documentation that the nitial evaluation and ongoing tents by a physician since rns. The facility failed to igate the circumstances incident. The facility failed to igate the facility failed to incident facility. The facility failed to igate the facility failed to incident facility.	, F3	323 4.) This will be DNS, Administrate Director. The answers to the are not an admission they cannot be the in a court of latter Medicaid and the Medicaid and	the stated def ssion fo guilt used against t aw. They are	iciencies Therefor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		ENCIES (X1) PROVIDER/SUPPLIER/CLIA TION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C 06/16/2006		
	135018		B. WING					
NAME OF PROVIDER OR SUPPLIER HILLCREST HAVEN CONVALESCENT CTR				1	REET ADDRESS, CITY, STATE, ZIP CODE 1071 RENEE AVE POCATELLO, ID 83201			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 323	will add language to stating that this fac heating pads. We were sident inventory allowed. The facility all residents and the them of the policy of this facility. The facility are sidents and the them of the policy. Staff of the policy. As noted during the unit clear billion. The facility present statement, signed if 6/15/06 at 4:00 pm checked rooms for none were found Findings include: Resident #1 was ad 4/12/06 with diagnor cerebral vascular avascular dementia, edema, leg pain, particular demential documented "(1)	e facility for resident use. We of our admission agreement ility does not allow the use of will also make a notation on our ist that heating pads are not y will also send a notice out to eir interested parties informing of not utilizing heating pads in cility will provide quarterly or re-educate and remind them will monitor rooms for heating uality assurance rounds and ans which are scheduled and in the statement the facility esident to the emergency room valuation by a physician. will be completed by the stated the following: "I heating pads per your request," I dmitted to the facility on one including history of eccident, osteoarthritis, neuropathy, dysphagia, araparesis and low back pain. Intory list, attached to facility's able List," dated 4/22/06,	. ·	323	The answers to the st are not an admission they cannot be used a	of guilt. gainst th hey are n	Thereforis facilic	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		CIENCIES (X1) PROVIDER/SUPPLIER/CLIA CTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			JRVEY TED	
		135018	B. WIN	IG		C 06/16/2006		
NAME OF PROVIDER OR SUPPLIER HILLCREST HAVEN CONVALESCENT CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 1071 RENEE AVE POCATELLO, ID 83201					
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F 323	Report," dated 5/18 two CNAs had enter her up and discove her heels." The rep "observed some is and notified a nurse Attached to the inci Report Investigation investigation report information: "This morning at into [resident #1's] is preparations for the blankets down, they feet, between the heating pad, some right heelUpon investigation investigation investigation investigation for the blankets down, they feet, between the heating pad for the placed on her feet a had just assisted he resident had been prior when she was and physician were spoke with the staff inservicing them on utilize any heating protified and the heating pad in from the building." The resident's nursidocumentation reversigned in from the pad in from the pad in from the pad to be pad to be pad to the	i/06 at 7:20 am, documented fred the resident's room to get red a heating pad "between ort documented the CNAs redness on the Right heel"	F3		The answers to the stare not an admission they cannot be used a in a court of law. The Medicaid and Medicaid	of guilt. against tl They are 1	Therefor ais facilit equired by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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Ę 323	[sic] found heating arriving to work for blisters on feet, in doctor], Son has shome." At the request of 5/18/06, wrote a shoted that when showed that when showed the skin should be showed the showed the skin should be showed the skin should be showed the sho	g pad, put on Res feet, when or shift, observed Res [with] 2 otified family [and] MD [medical stated he was going to take pad the surveyors, the LN on duty on statement on 6/15/06. The LN she arrived in the resident's red "a heating pad under her ght] foot and ankle" Upon the leg, the LN noted "a red and bottom of foot, when I around the red area it LN documented that she had st aid for the reddened area and of the resident's foot. The LN at 0930 [9:30 am] the aid [sic] once again to look at the ankle. Trapped the foot and I observed a blister on it and the red area ottom of foot was blistered. In/new non-adhesive pads and Is of curlex [sic] and re-wrapped the and put the AFO [ankle-foot]	F 32	The answersato the are not an admissi they cannot be use in a court of law. the Medicaid and M	on of guilt. d against thi They are re	Therefor s facilit quired by

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ULTIPI LDING	LE CONSTRUCTION	(X3) DATE SU COMPLE		
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F 323	documented the for heating pad on he [11:00 pm]. She wat 0100 [1:00 am] repositioned. Uncliplaced on her [low notified the nurse [lower] leg/feet patthought the heating asked him to turn 2nd or 3rd setting, was white [with] a On 6/15/06 at app surveyors observe foot during a dress heel and lower exting a reclined positing protectors on. The Kerlix wrap which protector. The expextremity, beyond be very red, taut a approximately 20 ankle region. The and the dressings Kerlix wrap a faint area of the wound approximately 5 feextremity. As the sof the wound, the following was observed.	ollowing: "Stated he saw the rechest on 1st Rounds [at] 2300 as checked for bathroom need 0300 [3 am] [and] also ear as to when the pad was er] legs [and] ankles but [at] the time that she was c/o in. [NA's name] said that he g pad had 4 settings [and] she it up. He thought he set it on the Recalled that the heating pad white cover." Toximately 3:00 pm, the id the resident's right leg and sing change to wounds on her remity. The resident was sitting on. She had bilateral heel right lower extremity had a extended beyond the heel cosed area of her anterior lower the Kerlix wrap, was noted to not edematous. This area was centimeters (cms) above the LN removed the heel protector. As the LN was removing the foul odor was emitted from the foul odor was emitted from the surveyor leaned within 2 - 3 feet odor was more apparent. The erved:	_* F:	323	The answers to the st are not an admission they cannot be used a	of guilt. gainst tl hey are i	Theref nis facil equired	þr it
	firmly attached bla 4.5 -5.0 cms. The was deep red, me	dial right heel was covered by ck, dry eschar, measuring 4.0 x immediate surrounding skin asuring 4.5 cms inferiorly, 1.0 2.5 cms superiorly to the eschar						

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STATEMEN' AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IULTIPI LDING	LE CONSTRUCTION	(X3) DATE SU COMPLE	
		135018	B. WII	۷G		ı	6/ 2006
	ROVIDER OR SUPPLIER			107	EET ADDRESS, CITY, STATE, ZIP CODE 71 RENEE AVE DCATELLO, ID 83201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 32.3	resident's medial 3.6 to 4.8 cms above was irregularly shapproximately 3.5 covered with 50 - The remainder of granulating tissue skin was deep recalong the inferolations along the surpreviously. The resident's sor approximately 3:1 the heating pad in admitted "when know it was agains son stated he had circumstances surtold him that she had circumstances surtold him that she habit, asked for it. The DON was interegarding the burn 5/18/06. She state heating pad on [re on all nightthe fat that day" The DO admitted to placing resident initially an twice" during the seeing the heating time during the nigheating pad on he	as a second wound along the lower extremity, approximately ove the heel eschar. This wound aped and measured x 4.0 cms. The wound bed was 60% pale yellow mucoid tissue, the wound bed contained pink. The immediate surrounding 1, measuring from 0.5 - 1.0 cm eral wound margins, to 2.0 - 4.5 perolateral wound margins. The emity intact skin was described 1 was interviewed on 6/15/06 at 10 pm. He indicated he brought shortly after the resident was 1 moved her things inI didn't st the rules" The resident's spoken with her regarding the rounding the burns and she had asked the aides to put it on so due to pain and as per her to be set on the lowest setting. Arviewed on 6/15/06 at 3:50 pm, as the resident sustained on d, "the CNAs found the sident #1] at 0600it had been milly brought the heating pad in DN noted that no-one had a the heating pad on the d that she had been "toileted inght and no-one remembered pad. She stated, "at some tht, someone placed the richest" and at 6:00 am, staff d between the resident's heels.	F	323	The answers to the stare not an admission of they cannot be used again a court of law. The Medicaid and Medic	of guilt. gainst th Hey are r	Therefore, is facility equired by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED			
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	ROVIDER OR SUPPLIER	ESCENT CTR	s	STREET ADDRESS, CITY, STATE, ZIP CODE 1071 RENEE AVE POCATELLO, ID 83201		
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F 323	Continued From pa	age 30 💃 💃	F 32	23,	% %	
	6:30 pm, regarding the heating pad ind stated she did not immediately after shursing notes" Wobserved the burnsyou saw them" On 5/23/06, via telerequested a physical therapy notes and treat physical therapy notes assessment of the treatment to consist per week and as notes as necessary. Revitreatment was performed on this sinvestigation of 6/1 Documentation frow visit on 6/15/06 revert [patient] Needs for debridement of Rocephin [1] GM [piggy-back] Daily, then Return immed Department - fever pain. [Name of res 3 days [underscore and length time on the state of the	m the resident's emergency realed the following orders: "1) Aggressive Physical therapy [right] ankle [and] foot daily. 2) gram] IVPB [intravenous of any [underscored] worsening diately to Emergency rechills - Rigors - [increased] ident's physician] to see within ed] to establish treatment plan		The answers to the sare not and admission they cannot be used in a court of law. the Medicaid and Med	of guilt against th They are	Thereford is facility equired by
	6/15/06, revealed a [right] lower leg se	a diagnosis of "acute cellulitis condary to burn and large tus is of heel burn medial leg at				

NAME OF PROVIDER OR SUPPLIER HILLCREST HAVEN CONVALESCENT CTR STREET ADDRESS, CITY, STATE, ZIP CODE 1071 RENEE AVE POCATELLO, ID 83201 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1071 RENEE AVE POCATELLO, ID 83201 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE	AND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUI		G	COMPLE	TED	
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PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE			ESCENT CTR		10	071 RENEE AVE			
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F 323 Continued From page 31	F 323	Continued From pa	age 31	F	323	ę ę	·	ţ	
ankle." The resident's wound was cultured and an emergency room notation, dated 6/18/06, documented a positive MRSA (Methicillin The answers to the stated deficiencies		ankle." The resider emergency room in documented a pos Resistant Staphylo The resident was son 6/19/06 for furth notes documented change her meds [culturesWill have about her heel and of physician] about The facility did not environment was finazards by allowing The facility's staff of the heating pad on Despite observing on at least 2 occas remove it and one turned it up to the 'the facility's failure the resident sustain thermal burns to he extremity which resimmediate jeopard investigation, the resurrounding tissue and edematous. The burns. The emergence in the facility approximate the burns. The emergence in the facility started ordered "aggress debridement of [rig resident's regular president's regular p	nt's wound was cultured and an otation, dated 6/18/06, itive MRSA (Methicillin coccus Aureus) culture. seen by her personal physician her evaluation. The physician's the following: "Plan: Will medications] to match her wound specialist see her right legShe is to see [name her pain control" ensure the resident's ree from environmental g a heating pad into the facility. It documented the presence of 4/22/06 on an inventory list. It he heating pad on the resident sions, facility staff failed to staff member admitted he her included and 3rd degree er right heel and lower sulted in harm and subsequent young the time of the complaint esident's burns and were observed to be inflamed the resident had not been seen after the surveyors entered mately 27 days after sustaining ergency room physician dithe resident on antibiotics, sive physical therapy for ht] ankle" and requested the ohysician examine her within 3			The answers to the st are not an admission they cannot be used a in a court of law. T	ated def of guilt gainst t hey are	iciencies . Therei nis facil required	bro

STATEMENT AND PLAN O	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII	LDING)	1	TED	
	ROVIDER OR SUPPLIER	135018 ESCENT CTR		STRI	EET ADDRESS, CITY, STATE, ZIP CODE 171 RENEE AVE OCATELLO, ID 83201	06/10	6/2006	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	1	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 323	with MRSA infectio aggressive treatme referral to a wound suffered from phys	n in her wound and required ant with antibiotics as well as a specialist. The resident ical and psychological trauma be burns and was often afflicted	F3	323	The answers to the stare not an admission cannot be used agains court of law. They a Medicaid and Medicare	of guilt t this f re requi	and ther acility i red by th	efore n a
F 441 SS=G	The facility must exinfection control prosafe, sanitary, and to prevent the development of the facility; decides isolation should be resident; and main corrective actions of the facility decides isolation should be resident; and main corrective actions of the facility did not ensure the facility did not ensur	stablish and maintain an ogram designed to provide a comfortable environment and elopment and transmission of on. The facility must establish program under which it ols, and prevents infections in what procedures, such as applied to an individual tains a record of incidents and related to infections. NT is not met as evidenced the it was determined the ure that 1 of 1 sampled resident er wound care to prevent	F	441	1.) This facility has and program in place. The follow our program rechanges. The nurse is reprimanded and has mon proper procedures 2.) All licensed staff programs on dressing attend the inservice, strate the proper procedures a dressing, the Inservice once the staff member cedure flawlessly. Then demonstrate the 3.) Inservices will be erly regarding dressing the staff member cedure flawlessly.	e nurse garding n questi eceived for chan will att changes. they wi cedure f vice Dir the dem perform he staff procedur held at ng chang	failed to dressing on has be inservice ging dres end inser the last quest of the least quest.	en sing. vice ey emon- ng 1 n and eadur ill DNS. arter fowid
	Findings include: Resident #1 was a 4/12/06 with diagnorerebral vascular a vascular dementia	dmitted to the facility on oses including history of accident, osteoarthritis, neuropathy, dysphagia, araparesis, low back pain and			will demonstrate the our Inservice Directo at least yearly 4.) Our Inservice Dir our DNS will monitor our policies and proc	ector, C	r our QA A nurse a gram to e	nurse nd nsure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (2)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		135018	B. WIN				06/14	5 6/ 2006	
	PROVIDER OR SUPPLIER			10	REET ADDRESS, CITY, STATE, ZIP 071 RENEE AVE POCATELLO, ID 83201	CODE	1 00/10	572000	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES (MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHO	OULD BE	(X5) COMPLETION DATE	
Ę 441,		roximately 3:00 pm, two	F _v 4	41	%	\$	[©] .		
	surveyors observed resident #1's right present in the resident #1's right present in the residence on, the DON and The LN placed a tobarrier under the reflective barrier under the reflective barrier. It is placed the package floor rather than or protective barrier. It removed the contadiscarded the dress removing his contahis hands, he clean pads. He removed from its package at the window sill. The started to use the swithout first sanitized member left the ropads which the LN After he applied the and still wearing his picked up the Kerlix wrapped the residence contaminated glove He used this tape to only for this residence contaminated glove hands, he picked up the kerlixer only for this residence contaminated glove hands, he picked up the kerlixer only for this residence on the picked up the kerlixer only for this residence on the picked up the kerlixer only for this residence on the picked up the kerlixer on the picked up the kerlixer on the picked up the kerlixer of the picked up t	d an LN perform wound care to heel and lower extremity. Also dent's room were the resident's a physical therapy assistant. Swel rather than a protective esident's right lower extremity. Sors on the window sill and ed wound care supplies on the in a clean surface draped by a He applied clean gloves and similated dressings. He sings, and without first aminated gloves and sanitizing insed the wounds with gauze the petroleum gauze dressing and retrieved the scissors from the scissors to cut the gauze ing the scissors. A staff om and brought back alcohol used to clean the scissors. It wound contact dressings, as contaminated gloves, he is package from the floor, a from the package and the scissors to cut the gauze in the scissors. It is not and lower extremity, his uniform pocket with the earnd removed a roll of tape. To secure the Kerlix instead of the and removed a roll of tape. To secure the Kerlix instead of the and without sanitizing his up the remainder of the wound			The answers to tare not an admis they cannot be usin a court of lathe Medicaid and	sion sed a w. T	of guilt. gainst th They are r	Therefis facil	ere ity
	left the room. The	the contaminated scissors and surveyor observed him to place counter at the nursing station.							

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FUKIV OMB NIC	0. 0938-0391	
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	ILTIPLE CONSTRUCTION DING	(X3) DATE S	SURVEY	
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	ROVIDER OR SUPPLIER	ESCENT CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 1071 RENEE AVE POCATELLO, ID 83201		7,2000	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE	10ULD BE	(X5) COMPLETION DATE	
F 441	After the LN returns assisted the physical the resident in bed. The bed fell to the fillinen, the staff put to lower extremities. Asstained with large serosanguinous fluit assistant placed the resident's recliner in case and sanitizing. The resident was to Room that same after and treatment second to her right lower extaken at the Emergiments.	the LN returned to the resident's room, he ed the physical therapy assistant to place sident in bed. The bed linen at the foot of d fell to the floor. Instead of obtaining clean the staff put this linen over the resident's extremities. A pillow was observed to be d with large spots of dried to drying anguinous fluid. The physical therapy ant placed the contaminated pillow on the nt's recliner instead of removing the pillow and sanitizing the pillow. The resident was transported to the Emergency that same afternoon for wound evaluation eatment secondary to an apparent cellulitis right lower extremity. The wound culture at the Emergency Room identified of the resident required intravenous		The answers to the st are not an admission they cannot be used a in a court of law. T the Medicare and Medi	of guilt. gainst th hey are r	hTherefor is facilit equired by	y
SS=G	antibiotics. 483.75 ADMINISTE A facility must be ac enables it to use its efficiently to attain o practicable physical well-being of each r This REQUIREMEN by: Based on observations reports, record revisions complaint from the	ATION Iministered in a manner that resources effectively and or maintain the highest , mental, and psychosocial	F 49	has been reviewed and she reaches her higher physical, mental and being. 2.) This facility has procedures that cover	l revised est practi psychosoc es policie dech aspector has been restrator has ensuring to	to ensure cal ial well-s and ect of this viewed and hese polic	

CENTÈ	RS FOR MEDICARE	& MEDICAID SERVICES				FURM OMB NO	APPROVED . 0938-0391	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION NG	(X3) DATE S COMPLI	URVEY	
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NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
HILLCRI	EST HAVEN CONVALI				1071 RENEE AVE POCATELLO, ID 83201			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 490	not manage the fac prevented immedia: of one sampled resisecond and third de resident's right lowe of an unstageable pand poorly controlle Administrator did not thermal injury to rule Additionally, the Adr Nursing did not ensiprocedures were impossibility of neglect transmission of infermal injury to rule Additionally, the Adr Nursing did not ensiprocedures were impossibility of neglect transmission of infermal for harm to citations: 1. Resident #1 was a pressure ulcer to have a large unstageable. The resident did not	ility in a manner which te jeopardy and harm to one ident (#1). This resulted in gree thermal burns to the gree thermal burns to the greesure ulcer to the right heel, d pain management. The of thoroughly investigate the e out neglect or abuse. ministrator and Director of ure that policies and plemented to prevent the or abuse and the ction. Findings include: to Administrator management te jeopardy, harm, and the Resident #1 in the following admitted to the facility without her right heel. She developed pressure ulcer to the site. receive the necessary care	F	490	management, accident in care and skin assessment be required to abide by times. 4.) This will be monit service Director, our I strator The answers to the state are not an admission of they cannot be used again.	ted defifications the defifications and the defifications and the definitions are responsed to the defifications at the definitions are responsed to the definition and the definition are responsed to the definition are responsed	tions, wo lästaffew licies at our In- the Admin 7-20-06 ciencies Therefo is facili equired b	und ill all i- te, ty
	and services to prev The facility did not p assessments which beginnings of a stag of preventative mea- assessments led to unstageable pressur	ent the ulcer from developing. erform appropriate skin would have identified the e 1 pressure injury. This lack sures and ongoing skin the development of a large re ulcer which constituted Please refer to F 314.						
*	environment remainers as possible. This fail serious harm, consti	co ensure a resident's ed free of accident hazards ed practice resulted in tuting immediate jeopardy to aced a heating pad on or	š	***************************************	5 5	*		*

STATEMENT AND PLAN (OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION ING	(X3) DATE SI COMPLE	
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F 490	near the resident's causing thermal but degree level. The riburns to the right mover extremity on refer to F 323. 3. The Administrate investigate an incident to rule out sustained second at the right heel and 5/18/06 from a hear feet and ankles resulting the incident was moved and the right heel and 5/18/06 from a hear feet and ankles resulting in hear on 5/17/06 or 5/18/increasing pain over days resulting in hear on 5/17/06 or 5/18/increasing pain over days resulting in hear on the residence of the the valuation and ong a physician since supervision, assess received for resident supervision, as received for resident supervision, as received for resid	feet and lower extremities irns at the second and third resident sustained thermal hedial heel and right medial 5/17/06 or 5/18/06. Please or failed to thoroughly lent regarding a specific abuse or neglect. Resident #1 and third degree thermal burns d lower extremity on 5/17/06 or ting pad placed on or near her sulting in harm to the resident. The ot thoroughly investigated. 25. Italied thermal burns to the had right medial lower extremity 06. The resident experienced for the course of the next 27 arm to the resident. There was a resident had an initial oing medical assessments by sustaining the burns. Please or failed to ensure medical sment and management was ant #1. This resulted in harm sustained pressure ulcers, d uncontrolled pain	F 4		The answers to the state are not an admission of they cannot be used as	of guilt. gainst th hey are r	Thereforms facility equired by

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1''	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED				
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F 490		ge 37 ntial for harm to this resident s in the facility. Please refer to	F	190	The answers to the sta are not an admission o they cannot be used ag in a court of law. Th the Medicaid and Medic	f guilt. ainst th ey are r	Thereforis facili	e, ty
F 501 ⁻ SS=G ·	The facility must de as medical director The medical director implementation of r	signate a physician to serve	F		l.) This facility has Directors on contract, neither were called in case. However, the resseen by emergency room attending physician. been revised and her pheing managed effectly	unforte to assistent had physical Her care	nately st on the s now be ans and plan ha	en her s
	by: Based on observation interview, and a condetermined the facion medical director regithe resident continuous uffering from her swounds which were This resulted in har sustained thermal thand right medial low 5/18/06 and experied course of the next 2 1 sampled resident Resident #1 was according to the sample of the sampl	on, record review, staff implaint from the public, it was lity failed to involve the garding a resident's care when sed to experience pain and second and third degree is being inadequately managed. In to the resident who purns to the right medial heel over extremity on 5/17/06 or enced increasing pain over the extra contraction of the extra con			 Our Medical Directies the role of the Medical write a policy for which will specify the nursing staff should ocase. Staff will receive role of our Medical Dishould askithe DNS to Director to intervene appropriate care is not the residents attending the PNS will be moniful. This will be moniful QA Nurse and the Adminitations. 	dedical land the post of the p	Director. Aicy mannes and when the Medic feel the given by the DNS	We ual en the they al
š	cerebral vascular a vascular dementia, edema, leg pain, pa	ccident, osteoarthritis, neuropathy, dysphagia, araparesis and low back pain.		*	ž		7-20-00	

PRINTED: 06/29/2006 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A, BUILDING. C B. WING_ 135018 06/16/2006 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1071 RENEE AVE** HILLCREST HAVEN CONVALESCENT CTR POCATELLO, ID 83201 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 501 Continued From page 38 F 501 second and third degree burns when a heating pad was left on or near her lower extremities for The answers to the stated deficiencies an extended period of time. are not an admission of guilt. Therefore, they cannot be used against this facility Review of the resident's nursing notes from in a court of law. They are required by 5/18/06 through 6/15/06 documented the resident the Medicaid and medicare programs. received poor pain control management when it was identified that her pain level was at times as high as 7 or 8 on a 1 to 10 pain scale even though she was receiving narcotic medication. Nursing staff did not recognize the importance of being proactive and assess and medicate the resident at regular intervals to ensure her pain was minimal and keep her as pain free as possible. When the facility involved the resident's personal physician, nursing note documentation revealed "Phys [physician] returned call refused stronger Pain med. Suggest pain specialist appointment..." On 5/30/06, eight days later, the nursing notes documented, "... [name of pain specialistl was attempted per phone for pain consult." At the time of the complaint investigation, the resident still had not been evaluated by a pain specialist for her uncontrolled pain. The facility failed to advocate for the resident in order to ensure pain control was properly managed by either transferring her to the

emergency room or contacting the medical director when staff was fully aware the resident

The facility did not ensure the resident received appropriate medical management and ongoing medical treatment after she sustained the thermal burns which caused increased uncontrolled pain. No physician evaluated the resident's burns until 6/15/06, nearly a month after the initial injury, when the surveyors called immediate jeopardy

was suffering from uncontrolled pain.

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION IG	(X3) DATE SU COMPLE		
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F 501	emergency room, emergency room, with acute cellulitis intravenous antibio physician ordered treating physician ordered and required aggreas well as a referration and required aggreas well as a referration of policy regarding director in the facilinursing staff docur communication boa call back from a documented in the follow-up. The Ass remembered readi in the communication the communication documented in the communication of the communication documented in the communication documented in the communication documented in the documented in the communication docum	ent be transported to the Upon evaluation at the the resident was diagnosed and was started on tics. The emergency room the resident to be seen by her within 3 days and to begin ical therapy for debridement of resident was subsequently RSA (Methicillin-resistant reus) infection in her wound essive treatment with antibiotics all to a wound specialist. Inducted with the Assistant the DON on 6/15/06 at 10 pm. The DON could provide 10 pm. The DON stated that mented concerns in a 10 physician, it would be 10 physician. The 10 physician. The 10 physician. The 10 physician. The 10 physician in the communication of the physician in the communication of the root information regarding 10 physician and physician in the communication of the root of th	F		The answers to the star are not an admission of they cannot be used again a court of law. The Medical and Medical	f guilt. ainst th: ey are re	Therefor s facilit	v

(X1) PROVIDER/SUPPLIER/CLIA

FATEMENT OF DEFICIENCIES

PRINTED: 06/29/2006 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

4D PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	NG	COMPLE	ETED	
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•		• •		The answers to the st an admission of guilt be used against this They are required by programs.	. therefor	e, they canr a court of	ot 1a
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j				1			

(X2) MULTIPLE CONSTRUCTION

PRINTED: 06/29/2006 FORM APPROVED Bureau of riacility Standards (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 06/16/2006 135018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1071 RENEE AVE** HILLCREST HAVEN CONVALESCENT CTR POCATELLO, ID 83201 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (D (X5) (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) C 000 C 000 INITIAL COMMENTS The answers to the stated deficiencies Therefore, are not an admission of guilt. The Administrative Rules of the Idaho they cannot be used against this facility Department of Health and Welfare. Skilled Nursing and Intermediate Care in a court of law. They are required by Facilities are found in IDAPA 16, the Medicaid and Medicare programs. Title 03, Chapter 2. The following deficiencies were cited during a complaint investigation at the facility. The surveyors conducting the survey were: Marcia Key, RN Team Coordinator Lisa Kaiser, RNSurvey Definitions: BECEIVED MDS = Minimum Data Set assessment JUL 10 2006 RAP = Resident Assessment Protocol RAI = Resident Assessment Instrument DON = Director of Nursing FACILITY STANDARDS LN = Licensed Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record C 175 02.100,12,f C 175 Please see the answer to F225 as it pertains to this deficiency. 7-20-06 f. Immediate investigation of the cause of the incident or accident shall be instituted by the facility administrator and any corrective measures indicated shall be adopted. This Rule is not met as evidenced by: Please refer to F 225 as it relates to the facility's failure to thoroughly investigate incident/accidents to rule out abuse or neglect.

Bureau of Facility Standards

C 442 02.120,12,b

shall not be used.

LABORATORY DIRECTOR'S OF PROVIDER/SUPPLIER BEFRESENTATIVE'S SIGNATURE

b. Portable comfort heating devices

This Rule is not met as evidenced by:

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7/7/W

C 442

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMB	ER: A. BUILDING	(X3) DATE SURVEY COMPLETED	
	135018	B. WING	06/16/2006	
		TREET ADDRESS CITY STATE 710 CODE		

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HILLCREST HAVEN CONVALESCENT CTR

1071 RENEE AVE POCATELLO, ID 83201

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C 442	Continued From page 1 Please refer to F 323 as it refers to a residuent sustaining thermal burns as a result of state placing a heating pad on or near her lower extremities.	ff	Please refer to the answer to F323 as it pertains to this deficiency.	06
C 670	o2.150,03,a a. Applied aseptic or isolation techniques by staff. This Rule is not met as evidenced by: Please refer to F 441 as it refers to the fact failure to ensure a resident received proper wound care in order to prevent the possibilinfection or spreading infection.	er	Please refer to the answer to F441 pertains to this deficiency. 7-20	
C 784	b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Please refer to F 309 as it relates to the fafailure to adequately manage a resident's		Please refer to the answer to F309 pertains to this deficiency 7-20. The answers to the stated deficience are not an admission of guilt. They cannot be used against this fain a court of law.	-06 ies refo
C 789	v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Based on observations, staff interviews, re-	C 789	1.) We hired a Certified Wound Car specialist to assist in the followi areas:A.) Review our current wound care policies and procedures and revise as needed.B.) Oversee the wound care treatm in this facility.	ng them

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLII IDENTIFICATION NU				PLE CONSTRUCTION	(X3) DATE SI COMPLE					
				A. BUILDING	***************************************	- (
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HILLCRE	EST HAVEN CONVAL	ESCENI CIR	POCATEL	LO, ID 8320	11					
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C 789	C 789 Continued From page 2			C 789						
3 7 6 3	reviews, and a cordetermined the faction of develop a property of a constituting (#1) sampled residunstageable pressible. The facility coas to the circumstractually developed was evaluated. The appropriate managinterventions to product of the circumstracture of the circumstr	inplaint from the publicility failed to ensure a pressure ulcer while in practice resulted in some distributed in some distributed and provide no documence of when the heel in the facility or that the properties of the propriets of the propriet	a resident in the erious to 1 of 1 a large medial mentation I ulcer the heel lement e ation. The		C.) Provide insan ongoing basis program and approtechnique. 2.) The care plassis for this resident ensure she is reament as ordered to heal the wound developing any access of the control of the contro	regarding our opriate wound an and plan of thas been reviewing the property her attended and protect ditional skir completed ski	wound care care treatment ritten to oper treatment ng physician her from problems.			
	after the unstagea observed by the si extremity became failed practice. Th and third degree b	by also failed to notify the resident's physician the unstageable pressure ulcer was first rved by the staff. The right heel and lower mity became infected as a result of this dipractice. The resident sustained second third degree burns to the site which ributed to the infection.			table pressure ulcer was first taff. The right heel and lower infected as a result of this e resident sustained second burns to the site which			and the care plan needed (copies of fqxed to the surv 4.) Skin assess by our licensed of	ns have been to these assess veyors). ments will be staff and appropriate the staff and appropr	pdated where ments were performed opriate care
	This failed practice was brought to the a of the facility's Administrator, DON, and Administrator on 6/16/06, at 10:00 am. staff were provided with specific details failure to ensure the resident did not depressure ulcer.		Assistant These of the		Licensed sta	ese assessment following sche ion e no skin care aff will comply.	s will be edules: problems lete assess-			
	surveyors with an and the immediate	opm, the facility pres acceptable plan of co e jeopardy was abate	orrection		assessment skin integrand notify the	completion of there is impar- ity, Licensed attending phys	rment in the staff will sician, the			
of the state of th	"We will hire a CV Nurse] on a const following for this f	ction was as follows: VCN [Certified Wound ultant basis to perform acility: ertified wound care S the facility no later th	n the pecialist		Wound Care treatment and be developed begin immedian.) A nutrition.	amily and the Specialist. (nd a plan of the diand the treation in the treatin	orders for reatment will the will be			

Bureau of Facility Standards STATE FORM

If continuation sheet 3 of 17

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NU 135018			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		C 06/16/2006			
	ROVIDER OR SUPPLIER		1071 RENE	EET ADDRESS, CITY, STATE, ZIP CODE 1 RENEE AVE CATELLO, ID 83201				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	'FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
C 789	at 7:00 am. 2.) In order to ensure effected our Director RN is also completed assessments on evour facility and will in Monday, 6/19/06, b. 3.) Review our curring procedures including and revise these poensure this does not also assessments. In this facility. 5.) Provide inservice ongoing basis regal and appropriate words. Skin assessments licensed staff and adeveloped based of assessments will be schedules. 1.) Upon admission 2.) If there are no set aff will complete assessment there is integrity, licensed sphysician, the residence of the complete assessment there is integrity, licensed sphysician, the residence of the complete assessment and complete assessment there is integrity, licensed sphysician, the residence of the complete assessment and complete ass	re no other residents or of Nursing and one ing head to toe skin very resident curretnly fax these to the survey 2:00 pm. ent wound care policing treatment and preplicies where necessed occur again. ents of wounds on particular our straing our wound care rechniques will be performed by appropriate care plan in these assessment.	e are e other y [sic] in eyor on lies and vention ary. To atients in staff on a e program our s will be These ollowing eensed	C 789	Physicians of resident skin impairment will be supplements will be or account the residents. Additional dietary ass pleted on a monthly ba residents suffering from the sufficient from the suffering from the sufficient from the suffering from	e notifiedered take total conessments sis for tom skin in the cones of guilt.	ed and cing into dition. will be concided and concided an	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NU 135018		IMBER: A. BUILDII		LE CONSTRUCTION	(X3) DATE SE COMPLE	ETED C	
NAME OF D	DOMBED OD CHODINED	135018	STREET ADD	DRESS CITY S	TATE, ZIP CODE	06/1	6/2006
,,,	ROVIDER OR SUPPLIER EST HAVEN CONVAL	ESCENT CTR	1071 REN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIE MUST BE PRECEEDED B' SC IDENTIFYING INFORMA	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE		
C 789	Continued From pa	ige 4		C 789			
	4.) A nutritional assessment will be completed upon each admission. Physicians of residents who suffer from skin impairment will be notified and supplements will be ordered taking into accounts the Residents total condition. Additional dietary assessment will be completed on a monthly basis for those residents suffering from skin impairment. Date [to be] completed 6/23/06."				The answers to the stare not an admission they cannot be used a in a court of law. the Medicaid and Medicaid	of guilt. against th They are n	Thereforenis facility required by
	Findings include:						
	4/12/06 with diagnore cerebral vascular avascular dementia edema, leg pain, pressure ulcer to the complaint team 6/15/06 at 2:45 pm allegation that resi	dmitted to the facility oses including history accident, osteoarthrit, neuropathy, dyspha araparesis, low backne buttock region. m entered the facility in order to investigate the facility and the facility in order to investigate the facility are as a result of the second contents.	y of is, agia, c pain and on ate an ed second				
	use of a heating part for the resident's concern accompany the two room in order to villower extremity. The physical therapy a room with the survival.	ad. The complaint ter hart and requested to surveyors to reside sualize the resident's ne DON, the charge ssistant entered the reyors. The resident	am asked he DON to ent #1's s right LN, and a resident's was sitting				
- voi	She was wearing I right lower extrem extended beyond area of her anterio Kerlix wrap, was nedematous. This a	sitting in a reclined protector ity had a Kerlix wrap the heel protector. The lower extremity, be oted to be very red, area was approximate above the ankle red	ors. The which he exposed eyond the taut and ely 20				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPL IDENTIFICATION N 135018					(X3) DATE SURVEY COMPLETED C 06/16/2006		
	PROVIDER OR SUPPLIER EST HAVEN CONVAL	ESCENT CTR	STREET ADDR 1071 RENE POCATELL	E AVE	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCI MUST BE PRECEEDED B SC IDENTIFYING INFORM	SY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AIDEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
C 789	LN removed the he As the LN was rem foul odor was emitt The surveyor was a from the resident's surveyor leaned withe odor was more observed: The resident's mediant of the commedially, and 2 margins. There was deep red, mediant's mediant of 3.6 to 4.8 cms abowound was irregular approximately 3.5 covered with 50 - 6. The remainder of the granulating tissue. skin was deep red, along the inferolate cms along the supanterior lower extra previously. After viewing the rewounds, the survey Administrator, the DON at 4:30 pm. Examples and that werify that the "blad was still present at the survey of the control of the con	eel protector and the noving the Kerlix wrated from the area of standing approximated lower extremity. As thin 2 - 3 feet of the apparent. The following the apparent. The following the second wound assuring 4.5 cms inferse. 5 cms superiorly to see a second wound assuring 4.5 cms inferse. 5 cms superiorly to see a second wound assuring 4.5 cms. The would shapped and mean and the wound bed contained to the wound bed contained to the wound margins, perolateral wound margins, per	dressings. p a faint the wound. tely 5 feet the wound, wing was overed by suring 4.0 x ing skin riorly, 1.0 the eschar along the oximately This asured and bed was coid tissue. ained pink rounding 5 - 1.0 cm to 2.0 - 4.5 argins. The a described extremity eak with the ator and the the at was p" on her st could ent's heel at	C 789	The answers to the sare not an admission they cannot be used in a court of law. the Medicaid and Med	of guilt. against th They are r	Therefore is facility equired by

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED		٠	
		135018	p	<u> </u>		06/16	/2006	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, 8	STATE, ZIP CODE			
HILLCRE	ST HAVEN CONVAL	ESCENT CTR	1071 RENE POCATELL		01			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
C 789	Continued From pa	ge 6	7 7	C 789				
	telephone at 4:44 president was admittheel. The therapist asked him to assess instructed the staff attempt to remove was not sure if he owner was not sure if he owner was a blister. Once the blister op was again observed department had phothey initiated treatminist photograph tak original heel eschal	e to the physical ther im. The therapist indited to the facility with also indicated that a is the heel. He recall to keep the area dry the black eschar. He documented his asserted the original ened the original black. He also stated the otographs of the woment on 5/24/06. He is ten 5/24/06 showed for the agreed to produce and lower extremely expors.	icated the a black n LN ed he and not stated he essment oticed eschar. ck eschar therapy unds since stated the uce color		The answers to the sta are not an admisssion they cannot be used ag in a court of law. Th the Medicaid and Medic	of guilt gainst the ney are re	. Therefor is facility equired by	
	5/24/06 and docume heel wound is 7.3 or note that the heel with from the previous purn (she had a [sident]. The resident's admidated, 4/12/06, was surveyors. The Consection, also dated following: "Bruises legible] - rt [right] had billeg posterior & a [left] inner buttock nail It foot [word medial side of 5th theel protectors on."	by notes were review nented the following: om x 6 cm. It is imported the following: own decided and necrosis in the pressure ulcer and not intact heel cap pression nursing assess reviewed by the DC mprehensive Skin As 4/12/06, identified the Bil[ateral] areas from and swollen & bruise anterior - 4 cm open a fwords not legible] criot legible] 4th & 5th ince 2 inches long 1/8. The body diagram are the state of the state	"The retant to be center is bot from the eviously)". It is sment, DN and the essessment he is seessment he is area on it earn apply toe on deepBill on the					
	form identified the extremity bruising a	multiple upper and lo and the open area to ere was no identified	wer the right			A CAPTACA ANTINE		

Bureau of Facility Standards

PRINTED: 06/29/2006 FORM APPROVED **Bureau of Facility Standards** (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 135018 06/16/2006 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1071 RENEE AVE** HILLCREST HAVEN CONVALESCENT CTR POCATELLO, ID 83201 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRFFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) C 789 C 789 Continued From page 7 the resident's right heel. The admission nurses' notes, dated 4/12/06, also identified the above skin issues. There was no mention of a right heel The answers to the stated deficiancies injury. are not an admission of guilt. they cannot be used against this facility The physical therapist came to the facility 6/15/06 in a court of law. They are required by and was interviewed by the two surveyors at 6:10 the Medicaid and Medicare programs. pm. He stated he had attempted to locate his assessment notes for the time period when he evaluated the resident's heel. "I didn't see her when she first came in. I can't find my notes." He stated he was certain the resident had black eschar on her right heel prior to the thermal injury to the site. He acknowledged he was not sure if she was admitted to the facility with the pressure ulcer. The surveyors reviewed the Daily CNA Skin Check Sheet. The documentation identified from 4/13/06 through 5/18/06 that the resident had no impaired skin. This documentation contradicted the initial nursing assessment as identified earlier. The Skin Problem Assessment Flow Sheet was initiated on 5/18/06, the day the thermal injuries were sustained. The right heel was described as a "blister burn" and the color was "purple." There was no documentation prior to 5/18/06 that identified the resident had black eschar on the right heel.

There was no physician notification after the physical therapist became alerted by an LN that the resident had developed an unstageable pressure ulcer. There was no immediate care plan initiated to direct the staff how to protect the heel from further pressure and to protect other vulnerable areas prone to increased pressure.

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Bureau o	of Facility Standards						
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE S COMPLE	ETED
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDI	RESS, CITY, S	TATE, ZIP CODE		
HILLCRE	ST HAVEN CONVAL	ESCENT CTR	1071 RENE POCATELL		11		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIE MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	OTION SHOULD BE OTHE APPROPRIATE	(X5) COMPLETE DATE
C 789	The facility failed to assess, monitor and treat a large black eschar to the resident's right heel that developed after she was admitted to the facility. This failed practice resulted in immediate jeopardy.			C 789	The answers to the stated deficience are not an admission of guilt. The they cannot be used against this fain a court of law. They are require the Medicaid and Medicare programs.		
C 790				C 790	the facility 2.) The rooms of thoroughly are no other facility. 3.) Signs have indicating prohibited our admissing the use of We have alse forming fampolicy regard will provide remind staff heating pactific the QA communication of the QA commun	conment is as f	removed from sidents have bure there in our the facility ting pads is language to ndicating s prohibited cices in- lents of our pads. We nservices to cy regarding members of nitor the during their ns.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135018				(X2) MULTIP A. BUILDING B. WING		C OSMACIZAÇÃO		
	ROVIDER OR SUPPLIER		1071 RENI	06/16/2006 EET ADDRESS, CITY, STATE, ZIP CODE 71 RENEE AVE CATELLO, ID 83201				
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
C 790	Idaho state rules prin long-term care far long-term care far Prior to submitting correction, the surversident had been emergency room a 6/15/06. On 6/15/06, at appresented the surversident of correction and the abated. The plan of correct "Each resident at the environment free of have been searched may be in their room made and posted the policy of Hillcrest with pads allowed in the will add language the stating that this fact heating pads. We wour resident invention allowed. The fact of all residents and informing them of the heating pads in this provide quarterly in and remind them comes for heating pads in this provide quarterly in and remind them of the assurance rounds which are schedule statement the facilith emergency rooms.	rohibit portable heat acilities. an acceptable plan reyors were informe transported to a locat approximately 4:45 roximately 8:45 pm, eyors with an accepte immediate jeopal	of d that the al 5 pm on the facility stable plandy was sured an ent rooms ads that igns will be to a sto the no heating use. We reement the use of ation on pads are a notice out ties zing will re-educate all monitor ality cleans of the resident to evaluation of evaluation of the stable will re-educate ality cleans of the resident to evaluation of the resident to	C 790	The answers to the are not an admission they cannot be used in a court of law. The Medicaid and	n of guilt. against th They are r	Therefords facility equired by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		135018		B. WING _		06/16	; 6/2006
NAME OF P	ROVIDER OR SUPPLIER	100010	STREET ADD	RESS, CITY, S	STATE, ZIP CODE	1 00/10	0/2000
HILLCRE	EST HAVEN CONVAL	ESCENT CTR		ENEE AVE ELLO, ID 83201			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEEDED BY SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	(X5) COMPLETE DATE	
C 790	Continued From pa	ige 10		C 790			
	completed by 6/23/2006."				The answers to the sta	tod dofi	cionaina
	The facility presented the surveyors with a written statement, signed by a staff member, dated 6/15/06 at 4:00 pm, that stated the following: "I checked rooms for heating pads per your request, none were found"				are not an admission o they cannot be used ag in a court of law. th Medicaid and medicare	f guilt. ainst th ey are r	Therefore is facility equired by
	Findings include:						
	Resident #1 was admitted to the facility on 4/12/06 with diagnoses including history of cerebral vascular accident, osteoarthritis, vascular dementia, neuropathy, dysphagia, edema, leg pain, paraparesis and low back pain.						
		ntory list, attached to able List," dated 4/22 Heating pad"					
	A "Resident Incident/Unusual Occurrence Report," dated 5/18/06 at 7:20 am, documented two CNAs had entered the resident's room to get her up and discovered a heating pad "between her heels." The report documented the CNAs "observed some redness on the Right heel" and notified a nurse immediately.						
	Report Investigation	ident report was an " n, " dated 5/18/06. T included the followir	he				
	into [resident #1's] preparations for the blankets down, the feet, between the h heating pad, some	0720 [7:20 am], 2 Cl room to assist her w e day. As they pulled y noticed a heating p leels. When they ren redness was noted of vestigating the incide	ith the pad on her noved the on the				

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CATION NUMB			MBER: A. BUILDING		(X3) DATE SURVEY COMPLETED		
		135018		B. WING		06/1	6/2006
NAME OF P	ROVIDER OR SUPPLIER	133016	STREET ADD		TATE, ZIP CODE	1 00/11	0/2000
HILLCRE	ST HAVEN CONVAL	ESCENT CTR	1071 RENE POCATELI	EE AVE LO, ID 8320	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEEDED B	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLICATION CONTROL OF THE APPROPRIATE DEFICIENCY)		
C 790	PROVIDER OR SUPPLIER EST HAVEN CONVALESCENT CTR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		C 790	The answers to the sare not an admission they cannot be used in a court of law. the Medicaid and Med	of guilt. against th They are n	Therefore is facility equired by	
	documented, "A came and got me At this time, I unw	the resident's foot. t 0930 [9:30 am] the once again to look a rapped the foot and be blister on it and the	aid [sic] t the ankle. l observed				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		40 #040	•	B. WING		C	
		135018		1500 0171/ 0	TATE TIP CODE	06/16	3/2006
	PROVIDER OR SUPPLIER EST HAVEN CONVAL	ESCENT CTR	1071 RENE POCATELL	E AVE	STATE, ZIP CODE		***************************************
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIE MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
C 790				C 790	mi		
	then got two clean/ two clean/new rolls the ankle and foot orthoses] brace ba	ttom of foot was blisted in the contract of th	ads and e-wrapped kle-foot		The answers to the state are not an admission of they cannot be used again a court of law. The by the Medicaid and me	of guilt. gainst th ney are r	Therefore is facility equired
	who worked on 5/1 following: "Med[ica [4:30 am] for pain that she was c/o [c extremities. Had no n Res. [resident]]	8/06 and documente ted] [resident #1] [at] when he was notified omplaining of] pain ire knowledge of a hea [at] any time until he [night] [after] incident	d the 0430 by CNA n lower sting pad came to				
	worked the night sidocumented the following pad on her [11:00 pm]. She was at 0100 [1:00 am] or repositioned. Uncled placed on her [low notified the nurse [lower] leg/feet pait thought the heating asked him to turn in the comment of the nurse [lower] leg/feet pait thought the heating asked him to turn in the comment of	Illowing: "Stated he sinchest on 1st Rounds as checked for bathro 0300 [3 am] [and] also ear as to when the part of the time that she is at] the time that she is pad had 4 settings at the the thought he sing. Recalled that the	aw the s [at] 2300 com need o ad was but was c/o hat he [and] she set it on				
	surveyors observe foot during a dress heel and lower ext in a reclined position protectors on. The Kerlix wrap which protector. The exp extremity, beyond	roximately 3:00 pm, to the resident's right sing change to wound remity. The resident on. She had bilateral right lower extremity extended beyond the osed area of her antithe Kerlix wrap, was nd edematous. This	leg and is on her was sitting heel had a heel erior lower noted to				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLI IDENTIFICATION NI 135018				C 06/16/2006			
NAME OF PROVIDER OR SUPPLIER HILLCREST HAVEN CONVALESCENT CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 1071 RENEE AVE POCATELLO, ID 83201				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE	
C 790	(EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			C 790	The answers to the are not an admission they cannot be used in a court of law. The Medicaid and	on of guilt. d against th they are r	Therefore, is facility equired by

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
135018				B. WING		C 06/16/2006		
NAME OF PROVIDER OR SUPPLIER			STREET ADD	RESS, CITY, S	TATE, ZIP CODE	1 00/10	3/2000	
HILLCREST HAVEN CONVALESCENT CTR				1071 RENEE AVE POCATELLO, ID 83201				
PREFIX (EACH DEFIC				ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
C 790 Continued Fro	om pa	age 14		C 790				
The DON was regarding the 5/18/06. She heating pad on all nightt that day" The admitted to piece in the time during the heating pad of put the heating pad of put the heating pad of put the heating processory of the heating processory of the you saw then the per week and debridement revealed this recommended until the comparent pocumentation of 15/15/16	ST HAVEN CONVALESCENT CTR POCATELI			790	The answers to the stare not an admission they acoust be used a in a court of law. The Medicaid and Medicaid	of guilt. gainst th hey are r	Therefor is facilit equired by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SU COMPLE	TED	
135018				B. WING		3	6/2006	
NAME OF PROVIDER OR SUPPLIER			STREET ADD	RESS, CITY, S	TATE, ZIP CODE			
HILLCRE	EST HAVEN CONVAL	ESCENT CTR	1071 RENI POCATEL	EE AVE LO, ID 8320	1			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	TIVE ACTION SHOULD BE COMPLETE DATE		
C 790	Continued From pa	ige 15		C 790				
	piggy-back] Daily. If any [underscored] worsening then Return immediately to Emergency Department - fever - chills - Rigors - [increased] pain. [Name of resident's physician] to see within 3 days [underscored] to establish treatment plan and length time on antibiotics."				The answers to the are not an admissio they cannot be used in a court of law. by the Medicaid and	n of guilt. against th They are r	Thereford is facility equired	
	6/15/06, revealed a [right] lower leg sed decubitusDecubi at ankle." The resid an emergency root documented a pos	ergency room record, a diagnosis of "acute condary to burn and i tus is of heel burn mo dent's wound was cu m notation, dated 6/1 itive MRSA (Methicill coccus Aureus) cultu	cellulitis large edial leg ltured and 8/06, in					
	on 6/19/06 for furth notes documented change her meds [culturesWill have about her heel and	een by her personal ner evaluation. The pithe following: "Plan: medications] to mate wound specialist seright legShe is to see her pain control"	hysician's Will ch her e her					
	environment was f hazards by allowin The facility's staff of the heating pad on Despite observing on at least 2 occas remove it and one turned it up to the 'the facility's failure the resident sustai thermal burns to hextremity which reimmediate jeopard investigation, the r	ensure the resident's ree from environment g a heating pad into a documented the pressure 4/22/06 on an inventhe heating pad on the fions, facility staff fails staff member admitted in a staff member admitted in harm and staff the five sulted in harm and staff. At the time of the desident's burns and were observed to be	tal the facility. ence of tory list. he resident ed to ed he" Due to vironment, ree er ubsequent complaint					

135018 B. WING	
MAME OF PROVIDER OF SUPPLIED I STREET ADDRESS CITY STATE ZIP CODE	4
HILLCREST HAVEN CONVALESCENT CTR STREET ADDRESS, CITY, STATE, ZIP CODE 1071 RENEE AVE POCATELLO, ID 83201	-
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE OUT OF THE PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE DEFICIENCY)	
and edematous. The resident had not been seen by a physician until after the surveyors entered the facility approximately 27 days after sustaining the burns. The emergency room physician immediately started the resident on antibiotics, ordered "aggressive physicial therapy for debridement of [right] ankle. "and required aggressive treatment with antibiotics as well as a referral to a wound specialist. The resident suffered from physical and psychological trauma since sustaining the burns and was often afflicted with increasing unmanageable pain.	cre, Lity